DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 1 — 0 0 1

2. STATE: NEBRASKA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
1/1/01

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR, SUBPART C

7. FEDERAL BUDGET IMPACT:
a. FFY 2001 $ 0
b. FFY 2002 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
ATT. 3.1A, PAGE 7; ATT. 3.1B, PAGE 6;
ATT. 3.1A ITEM 15, PAGES 1-4;
ATT. 4.19D, PAGES 1-50

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
ATT. 3.1A, PAGE 7; ATT.3.1B, PAGE 6;
ATT. 3.1A, ITEM15A, PAGES 1-3;
ATT. 4.19D, PAGES 1-50

10. SUBJECT OF AMENDMENT:
REIMBURSEMENT OF ICF/MR AND NURSING FACILITIES

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
GOVERNOR HAS WAIVED REVIEW

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Robert J. Seiffert

13. TYPED NAME:
ROBERT J. SEIFFERT

14. TITLE:
MEDICAID ADMINISTRATOR

15. DATE SUBMITTED:
JANUARY 18, 2001

16. RETURN TO:
HHS, F&S
MEDICAID DIVISION
ATTN: DANA MCNEIL
P.O. BOX 95026
LINCOLN, NE 69509-5026

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
01/19/01

18. DATE APPROVED:
APR 05 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
JAN 01 2001

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Thomas W. Lenz

22. TITLE:
ARA for Medicaid and State Operations

23. REMARKS:

cc:
Curtiss
Seiffert

SRA CONTROL

Date Submitted: 01/18/01

FORM HCFA-179 (07-92)

Instructions on Back

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

15. Intermediate care facility services for persons determined, in accordance with section 1902(a)(31) of the Act, to be in need of such care, including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

_X_ Provided: ___ No limitations _X_ With limitations:

___ Not provided.

16. Inpatient psychiatric facility services for individuals under 22 years of age.

_X_ Provided: ___ No limitations _X_ With limitations:

___ Not provided.

17. Nurse-midwife services;

_X_ Provided: ___ No limitations _X_ With limitations:

___ Not provided.

18. Hospice care (in accordance with section 1905(o) of the Act).

___ Provided ___ No limitations ___ With limitations:

_X_ Not provided.

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All covered groups

c. Intermediate care facility services.

X Provided: ___ No limitations X With limitations*

15. Intermediate care facility services for persons determined, in accordance with section 1902(a)(31) of the Act, to be in need of such care, including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

X Provided: ___ No limitations X With limitations:

16. Inpatient psychiatric facility services for individuals under 22 years of age.

X Provided: ___ No limitations X With limitations:

17. Nurse-midwife services;

X Provided: ___ No limitations X With limitations:

18. Hospice care (in accordance with section 1905(o) of the Act).

___ Provided ___ No limitations ___ With limitations:

X Not provided.

Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: Nebraska

LIMITATIONS – ICF/MR SERVICES

ICF/MR Level of Care Criteria

The Department applies the following criteria to determine the appropriateness of ICF/MR services on admission and at each subsequent review:

1. The individual has a diagnosis of mental retardation or a related condition which has been confirmed by prior diagnostic evaluations/standardized tests and sources independent of the ICF/MR; and
2. The individual can benefit from "active treatment" as defined in 42 CFR 483.440(a) and 471 NAC 31-001.02. "Benefit from active treatment" means demonstrable progress in reducing barriers to less restrictive alternatives; and
3. In addition, the following criteria shall apply in situations where -
   a. The individual has a related condition and the independent QMRP assessment identifies that the related condition has resulted in substantial functional limitations in three or more of the following areas of major life activity:
      (1) self-care;
      (2) receptive and expressive language;
      (3) learning;
      (4) mobility;
      (5) self-direction; or
      (6) capacity for independent living;

      These substantial functional limitations indicate that the individual needs a combination of individually planned and coordinated special interdisciplinary care, a continuous active treatment program, treatment, and other services which are lifelong or of extended duration; and/or

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: Nebraska

LIMITATIONS – ICF/MR SERVICES

b. A Medicaid-eligible individual has a dual diagnosis of mental retardation or a related condition and a mental illness (i.e., mental retardation and schizophrenia). The mental retardation or related condition has been verified as the primary diagnosis by both an independent QMRP and a mental health professional (i.e., psychologist, psychiatrist); and -
   (1) Historically there is evidence of missed developmental stages, due to mental retardation or a related condition;
   (2) There is remission in the mental illness and/or it does not interfere with intellectual functioning and participation in training programs, i.e., the individual does not have active hallucinations nor exhibit behaviors which are manifestations of mental illness; and
   (3) The diagnosis of mental retardation or related condition takes precedence over the diagnosis of mental illness.

Inappropriate Level of Care: The following examples are not appropriate for ICF/MR services:

1. Mental illness is the primary barrier to independent living within a normalized environment; or
2. The ICF/MR level of care is not the least restrictive alternative, e.g., the client -
   a. Exhibits skills and needs comparable to those of persons with similar needs living independently or semi-independently in the community;
   b. Exhibits skills and needs comparable to those of persons at NF level of care; or
   c. Is able to function with little supervision or in the absence of a continuous active treatment program.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: Nebraska

LIMITATIONS – ICF/MR SERVICES

QMRP Approval Criteria: Under 42 CFR 483.430, a qualified mental retardation professional is a person who has at least one year of experience working directly with persons with mental retardation or related conditions and is one of the following:

1. A doctor of medicine or osteopathy;
2. A registered nurse;
3. An individual who holds at least a bachelor's degree or is licensed, certified, or registered and provides professional services in Nebraska in one of the following professional categories:
   a. An occupational therapist;
   b. A physical therapist;
   c. A psychologist;
   d. A social worker;
   e. A speech-language pathologist or audiologist;
   f. A professional recreation staff member;
   g. A professional dietitian; or
   h. A human services professional.

The Department uses these standards to approve individuals who conduct independent QMRP assessments.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: Nebraska

LIMITATIONS – ICF/MR SERVICES

Standards for a QMRP: To be approved by the Department to complete Independent QMRP Assessments, an individual shall submit the following information to the Department of Health and Human Services:

1. Proof of QMRP designation by an outside agency or program; or
2. Verification of -
   a. Education/degree (transcript);
   b. Licensure, registration, or certification, as applicable to the profession (copy); and
   c. One year's experience in working directly with persons with mental retardation. The individual shall indicate the following skills related to his/her job experience in a mental retardation facility/program:
      (1) Assessing the need for specific goals and objectives;
      (2) Writing behaviorally-stated goals and objectives in training programs;
      (3) Conducting or carrying out training programs; and
      (4) Evaluating, documenting, and summarizing training programs.

Department staff shall review the submitted information and, if approved, shall issue a formal letter of approval to the applicant.

The Department may withdraw approval of any QMRP who has been advised by Nebraska Department of Health and Human Services that his/her assessments are lacking in quality and/or completeness.

Telehealth: ICF/MR services are covered when provided via telehealth technologies subject to the limitations as set forth in state regulations, as amended.

12-011 Rates for Nursing Facility Services

12-011.01 Purpose: This section -

1. Satisfies the requirements of the State Plan for Medical Assistance and 42 CFR 447.250 through 42 CFR 447.272;
2. Adopts rate setting procedures which recognize the required level and quality of care as prescribed by all governmental entities (including, but not limited to, federal, state and local entities);
3. Establishes effective accountability for the disbursement of Medical Assistance appropriations; and
4. Provides for public notice of changes in the statewide method or level of payment pursuant to the requirements of Section 1902(a)(13) of the Social Security Act.

The rate determination described in 471 NAC 12-011.07 Rate Determination is in effect through December 31, 2000. The rate determination described in 471 NAC 12-011.08 is effective beginning January 1, 2001.

12-011.02 Definitions: The following definitions apply to the nursing facility rate determination system.

Allowable Cost: Those facility costs which are included in the computation of the facility's per diem. The facility's reported costs may be reduced because they are not allowable under Medicaid or Medicare regulation, or because they are limited under 471 NAC 12-011.06.

Level of Care: The classification (see 471 NAC 12-013.01) of each resident based on his/her acuity level.

Median: A value or an average of two values in an ordered set of values, below and above which there is an equal number of values.

Nursing Facility: An institution (or a distinct part of an institution) which meets the definition and requirements of Title XIX of the Social Security Act, Section 1919.

Per Diem Rates: Rates paid to nursing facilities under the Nebraska Medical Assistance Program. The rates are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities to provide services in conformance with state and federal laws, regulations, and quality and safety standards.

Urban: Urban areas are Dakota, Washington, Douglas, Sarpy, and Lancaster counties.

Waivered Facility: Facilities for which the State Certification Agency has waived professional nurse staffing requirements of OBRA 87 are classified as "waivered" if the total number of waivered days exceeds 90 calendar days at any time during the reporting period.

Weighted Resident Days: A facility's inpatient days, as adjusted for the acuity level of the residents in that facility (see 471 NAC 12-013.03 and 12-013.04).

Other definitions which apply in this section are included in Nebraska Department of Health and Human Services Regulation and Licensure's Regulations and Standards for Homes for the Aged or Infirm and Regulations and Standards Governing Centers for the Developmentally Disabled and appropriate federal regulations governing Title XIX and Title XVIII.

12-011.03 General Information: Wherever applicable, the principles of reimbursement for provider's cost and the related policies under which the Medicare extended care facility program functions (Medicare's Provider Reimbursement Manual (HIM-15) updated by "Provider Reimbursement Manual Revisions" in effect as of July 1, 2000 are used in determining the cost for Nebraska nursing facilities with exceptions noted in this section. Chapter 15, Change of Ownership, of HIM-15 is excluded in its entirety.

That portion of a provider's allowable cost for the treatment of Medicaid patients is payable under the Nebraska Medical Assistance Program (NMAP) except as limited in this section. The aggregate payments by the Department do not exceed amounts which would be paid under Title XVIII principles of reimbursement for extended care facilities.

12-011.04 Allowable Costs: The following items are allowable costs under NMAP.

12-011.04A Cost of Meeting Licensure and Certification Standards: Allowable costs for meeting licensure and certification standards are those costs incurred in order to -

1. Meet the definition and requirements for a Nursing Facility of Title XIX of the Social Security Act, Section 1919;
2. Comply with the standards prescribed by the Secretary of Health and Human Services (HHS) for nursing facilities or centers for the developmentally disabled in 42 CFR 442;
3. Comply with requirements established by the Nebraska Health and Human Services Regulation and Licensure, the state agency responsible for establishing and maintaining health standards, under 42 CFR 431.610; and
4. Comply with any other state law licensing requirements necessary for providing nursing facility or developmental disability center services, as applicable.

12-011.06 Limitations for Rate Determination: The Department applies the following limitations for rate determination.

12-011.06A Expiration or Termination of License or Certification: The Department does not make payment for care provided 30 days after the date of expiration or termination of the provider's license or certificate to operate under NMAP. The Department does not make payment for care provided to individuals who were admitted after the date of expiration or termination of the provider's license or certificate to operate under NMAP.

12-011.06B Total Inpatient Days: In computing the provider's allowable per diem rates, total inpatient days are the greater of the actual occupancy or eighty-five (85) percent of total licensed and certified bed days. For new construction (entire facility or bed additions) or a facility reopening, total inpatient days are the greater of the actual occupancy or fifty (50) percent of total licensed and certified bed days available during the first year of operation, beginning with the first day patients are admitted for care.

An inpatient day is:

1. A day on which a patient occupies a bed at midnight. When a client is admitted to a facility and dies before midnight on the same day, one day is counted and paid; or
2. A day on which the bed is held for hospital leave or therapeutic home visits.

Payment for holding beds for patients in acute hospitals or on therapeutic home visits is permitted if the policy of the facility is to hold beds for private patients and if the patient's bed is actually held. Bedholding is allowed for fifteen (15) days per hospitalization and for up to eighteen (18) days of therapeutic home visits per calendar year.

Medicaid inpatient days are days for which claims (Printout MC-4, "Long Term Care Facility Turnaround Billing Document") from the provider have been processed by the Department. The Department will not consider days for which a claim has not been processed unless the provider can show justification to the Department's satisfaction. Days for which the client's Medicaid eligibility is in a "spenddown" category are considered Medicaid inpatient days in compiling inpatient days. A facility may not impose charges that exceed the payment rate established under 471 NAC 12-011 ff. for these days.

12-011.06L Administration Expense: In computing the provider's allowable cost for determination of the rate, administration expense is limited to no more than 14 percent of the total otherwise allowable Direct Nursing. Direct Support Services, and Other Support Services Components for the facility.

This computation is made by dividing the total allowable Direct Nursing, Direct Support Services, and Other Support Services Components, less the administration cost category, by 0.86. The resulting quotient is the maximum allowable amount for the Direct Nursing, Direct Support Services, and Other Support Services components, including the administration cost category. If a facility's actual allowable cost for the three components exceeds this quotient, the excess amount is used to adjust the administration cost category.

12-011.06M Other Limitations: Other limitations to specific cost components of the rate are included in the rate determination provision of this system.

12-011.07 Rate Determination: The rate determination provisions of 471 NAC 12-011.07 are in effect through December 31, 2000. The Department determines rates for facilities under two distinct methodologies. Providers may chose either, following the respective guidelines for the methodology chosen, except that facilities which receive grant money from the Nebraska Health Care Trust Fund (Neb. Rev. Stat. 71-7605 to 71-7622 and 71-6050) to convert nursing facility beds to assisted living beds are referred to reimbursement provisions of 12-011.07B.

12-011.07A Cost-Based, Retroactively Adjusted Determination: The Department determines rates for this methodology under the following guidelines:

12-011.07A1 Rate Period: The rate period for each facility covers services provided July 1 through June 30 of each fiscal year. The final rate period under 471 NAC 12-011.07 covers services provided July 1, 2000 through December 31, 2000.

12-011.07A2 Reporting Period: Each facility shall file a cost report each year for the twelve-month reporting period of July 1 through June 30.

12-011.07A3 Care Classifications: A portion of each individual facility's rate may be based on the location and the waivered/non-waivered status of the facility. The care classifications are -

1. All Nursing Facilities in urban areas;
2. Nursing Facilities in urban areas which are non-waivered;
3. Nursing Facilities in urban areas which are waivered;
4. All Nursing Facilities in non-urban areas;
5. Nursing Facilities in non-urban areas which are non-waivered; and
6. Nursing Facilities in non-urban areas which are waivered.

12-011.07A5 Final Rates: Subject to the allowable, unallowable, and limitation provisions of 471 NAC 12-011.04, 12-011.05, and 12-011.06, the Department pays each facility retroactively determined per diem rates (one rate corresponding to each level of care) for the reasonable and adequate costs incurred and documented during each rate period. The rates are based on financial, acuity, and statistical data submitted by facilities for the most recent reporting period. Various care classification maximums as computed in this section are computed after initial desk audit, and are not revised based on subsequent desk audits or field audits.

The facility's final rates consist of four components:

1. The Direct Nursing Component;
2. The Direct Support Services Component;
3. The Other Support Services Component; and
4. The Fixed Cost Component.

The facility's final rates are computed as the sum of these components, subject to the rate limitations of this system. All four components are expressed in per diem amounts.

The final rates for the July 1, 2000 through December 31, 2000 time period are determined through cost reports filed for the July 1, 2000 through June 30, 2001 reporting period. The retroactive settlement of interim rates paid from July 1, 2000 through December 31, 2000, shall be adjusted using provisions of 471 NAC 12-011.07A6.

12-011.07A5a Direct Nursing Component: This component of the final rate is computed by dividing the allowable costs for nursing salaries (lines 94 through 103 of Form FA-66, "Long Term Care Cost Report") by the weighted resident days for each facility (see 471 NAC 12-013.03). The resulting quotient is the facility's "base" per diem. Each facility's base per diem is arrayed with all other facilities in the same care classification (see 471 NAC 12-011.07C), to include Classifications 2, 3, 5, and 6; the median base per diem is determined; and a maximum base per diem is computed at 125% of the median base per diem. If the maximum base per diem for waivered facilities in their respective urban or non-urban care classification is greater than the maximum base per diem for non-waivered facilities in that same care classification, the Department shall use the maximum base per diem for non-waivered facilities. Payment rates for the Direct Nursing Component for an individual facility are computed using the lower of its own base per diem, weighted for levels of care, or the maximum base per diem, weighted for levels of care.

12-011.07B Contracting Determination: As an alternative to rates defined under 12-011.07A, facilities may elect to contract with the Department for payment for nursing facility services. Effective January 1, 2001, all facilities that are contracting with the Department shall transition, as their contracting term expires, to rate determination per 471 NAC 12-011.08. Each facility's revised rate determination provisions are dependent upon whether the transition year is a Rebase Year or an Interim Year (see 471 NAC 12-011.08D and E). If the contracting term expires during a Rate Period, rates will be updated to the end of that Period using the then current Inflation Factor (see 471 NAC 12-011.08D5), as adjusted for the shortened remaining time. However, if a facility has less than 200 certified nursing facility beds, it receives a grant from the Nebraska Health Care Trust Fund Act to convert nursing facility beds to assisted living beds, and it provides both nursing facility and assisted living levels of care, the facility must contract for their nursing facility reimbursement. The Department determines rates for this methodology under the following guidelines:

12-011.07B1 General Contracting Provisions:

12-011.07B1a Effective Dates: Beginning August 1, 1998, any facility may request to contract with the Department. A contract may only go into effect on the first day of a month. A contract rate period begins the first day of the month following approval by the Department for a facility to contract, and is in effect for the following twelve months. If it is mandatory that a facility contract, the first contract rate period must begin no later than the first day of the month following the date which a Medicaid eligible resident is admitted to an assisted living bed.

12-011.07B1b Time Periods Covered: The facility's contract with the Department covers services provided: 1) from July 1 through the last day of the month before contracting begins, 2) from the first day of the month that contracting begins through the following twelve months, and 3) for the following three one-year extensions.

12-011.07B1c Termination from Contracting Provision: Unless a facility has received grant money under the Nebraska Health Care Trust Fund for the conversion of beds, it may terminate its contract following forty-five days notice to the Department. When a facility terminates its contract, nursing facility payment rates will be calculated under provisions of 471 NAC 12-011.07A. The rates received under contracting will continue as the facility's interim rates. If a facility terminates its contract. it is not eligible to contract again for a period of four years; if a change of ownership occurs, the four year period is waived.

A facility which has received a grant from the Nebraska Health Care Trust Fund for the conversion of beds may not terminate contracting provisions.

12-011.07B2 Notification: The facility must notify the Department of its desire to contract. Notification shall be postmarked no later than 45 calendar days before the facility's desired first contract rate period.

12-011.08 Rate Determination: The rate determination provisions of 471 NAC 12-011.08 are in effect beginning January 1, 2001. The Department determines rates for facilities under the following cost-based prospective methodology –

12-011.08A Rate Period: The rate period for each facility covers services provided January 1 through December 31 of each year. A Rate Period may be identified as either a Rebase Year or an Interim Year –

12-011.08A1 Rebase Year: A Rebase Year occurs January 1, 2001, and every third year thereafter, i.e., January 1, 2004, January 1, 2007, etc.

12-011.08A2 Interim Year: An Interim Year is every year that is not a Rebase Year.

12-011.08B Report Period: Each facility shall file a cost report each year for the twelve-month reporting period of July 1 through June 30.

12-011.08C Care Classifications: A portion of each individual facility's rate may be based on the location and the waivered/non-waivered status of the facility. The care classifications are -

1. All Nursing Facilities in urban areas;
2. Nursing Facilities in urban areas which are non-waivered;
3. Nursing Facilities in urban areas which are waivered;
4. All Nursing Facilities in non-urban areas;
5. Nursing Facilities in non-urban areas which are non-waivered; and
6. Nursing Facilities in non-urban areas which are waivered.

12-011.08D Prospective Rates for a Rebase Year: Subject to the allowable, unallowable, and limitation provisions of 471 NAC 12-011.04, 12-011.05, and 12-011.06, the Department pays each facility prospectively determined per idem rates (one rate corresponding to each level of care) based on the facility's allowable costs incurred and documented during the immediately preceding June 30th Report Period. The rates are based on financial, acuity, and statistical data submitted by facilities, and are subject to the Component maximums.

Component maximums are computed after initial desk audit, and are not revised based on subsequent desk audits or field audits. Only cost reports with a full year's data are used in the computation. Cost reports from providers entering or leaving the NMAP during the immediately preceding Report Period are not used in the computation.

Each facility's prospective rates consist of five components:

1. The Direct Nursing Component;
2. The Direct Support Services Component;
3. The Other Support Services Component;
4. The Fixed Cost Component; and
5. The Inflation Factor.

The facility's prospective rates are computed as the sum of these components, subject to the rate limitations of this system. The Direct Nursing, Direct Support Services, Other Support Services, and Fixed Cost components are expressed in per diem amounts. The Inflation Factor is a percentage computation.

12-011.08D1 Direct Nursing Component: This component of the prospective rate is computed by dividing the allowable costs for nursing salaries (lines 94 through 103 of Form FA-66, "Long Term Care Cost Report") by the weighted resident days for each facility (see 471 NAC 12-013.03). The resulting quotient is the facility's "base" per diem. Each facility's base per diem is arrayed with all other facilities in the same care classification (see 471 NAC 12-011.07C), to include Classifications 2, 3, 5, and 6; the median base per diem is determined; and a maximum base per diem is computed at 125% of the median base per diem. If the maximum base per diem for waivered facilities in their respective urban or non-urban care classification is greater than the maximum base per diem for non-waivered facilities in that same care classification, the Department shall use the maximum base per diem for non-waivered facilities. Payment rates for the Direct Nursing Component for an individual facility are computed using the lower of its own base per diem, weighted for levels of care, or the maximum base per diem, weighted for levels of care.

12-011.08D2 Direct Support Services Component: This component of the prospective rate is computed by dividing the combined allowable costs of: the Nursing Cost Center which are not included in 471 NAC 12-011.07E1 (lines 104 through 127 from the FA-66); raw food from the Dietary Cost Center (line 53 from the FA-66); plant utilities (lines 139 through 141 from the FA-66) and cable television service (line 143 from the FA-66) from the Plant Related Cost Center; the Activities and Social Services Cost Center (lines 164 through 183 from the FA-66); Resident Transportation - Medical from the Ancillary Cost Center (lines 211 through 218 from the FA-66); and respiratory therapy from the Ancillary Cost Center (line 203 through 210 from the FA-66), by the total inpatient days (see 471 NAC 12-011.06B) for each facility. Each facility's base per diem is arrayed with all other facilities in the same care classification, to include classifications 1 and 4; the median per diem is determined; and a maximum per diem is computed at 115% of the median per diem. Payment for the Direct Support Services Component for an individual facility is computed using the lower of its own per diem or the maximum per diem.

12-011.08D3 Other Support Services Component: This component of the prospective rate is computed by dividing the combined allowable costs of: the Administration Cost Center; the Dietary Cost Center, excluding raw food which is included in Direct Support Services; the Housekeeping and Laundry Cost Centers; and the Plant Related Cost Center, excluding utilities and cable television service, which are included in Direct Support Services, by the total inpatient days (see 471 NAC 12-011.06B) for each facility. Each facility's base per diem is arrayed with all other facilities in the same care classification, to include classifications 1 and 4; the median per diem is determined; and a maximum per diem is computed at 115% of the median per diem. Payment for the Other Support Services Component for an individual facility is computed using the lower of its own per diem or the maximum per diem.

12-011.08D4 Fixed Cost Component: This component of the prospective rate is computed by dividing the facility's allowable interest, depreciation, amortization, long-term rent/lease payments, personal property tax, real estate tax, and other fixed costs by the facility's total inpatient days (see 471 NAC 12-011.06B). Payment for the Fixed Cost Component for an individual facility is computed using its own per diem as computed above.

12-011.08D5 Inflation Factor: This component of the prospective rate is computed each Report Period from cost reports required to be submitted:

From all reporting facilities, facilities included in the computation are those that: 1) did not have more than a 3% increase or decrease in occupancy from the previous Report Period, and 2) maintained an occupancy level at 85% or greater (see 471 NAC 12-011.06B Total Inpatient Days).

Desk audited cost reports for the current and the previous Report Period for the remaining facilities are used.

Each facility's average cost per day for each period is computed, adjusted for increases/decreases in case-mix acuity, and then compared to this computation from the previous Report Period. Percentage changes are arrayed from low to high.

The Inflation Factor is the median percentage change, multiplied by 1.5 to adjust the Factor forward from the midpoint of the Reporting Period to the midpoint of the Rate Period. The Inflation Factor may not be less than "0%".

12-011.08E Prospective Rates for an Interim Year: Interim Year rates utilize each facility's prior Rate Period rates, increased by the Inflation Factor as computed per 471 NAC 12-011.08D5d, except that the median is not increased by the 1.5 adjustment factor.

12-011.08F Exception Process: For Interim Years only, an individual facility may request, on an exception basis, the Director of HHS Finance and Support to consider specific facility circumstance(s), which warrant an exception to the computed Inflation Factor. An exception may only be requested if the facility's adjusted cost per day increase as computed in 471 NAC 12-011.08D5c is 2 percentage points or more than the median increase. In addition, the facility's request must include:

1. Specific identification of the increased cost(s) that have caused the facility's total cost increase to be 2 percentage points or more above the median increase, with justification for the reasonableness and necessity of the increase;
2. whether the cost increase(s) are an ongoing or a one-time occurrence in the cost of operation; and
3. Preventive management action that was implemented to control past and future cause(s) of identified cost increase(s).

12-011.08G Out-of-State Facilities: The Department pays out-of-state facilities participating in NMAP at a rate established by that state's Medicaid program at the time of the issuance or reissuance of the provider agreements. The payment is not subject to any type of adjustment.